TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Sheryl P. Anderson

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-17-0787-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
November 21, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As documented in the initial clinical notes for date of service 7/12/2016, the provider was unable to obtain pre-authorization because the patient visit occurred after normal business hours and the referring physician wanted the brace to be applied that day to avoid potential additional injury to the patient's knee. …Authorization was later obtained from M. Moser, Adjuster with Texas Mutual, but after the initial application of the brace."

Amount in Dispute: $677.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The brace is durable medical equipment and is greater than $500.00. Preauthorization is required per Rule 134.600."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 12, 2016	L1832	$677.43	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the requirements for prior authorization.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent.
   - 930 – Pre-authorization required. Reimbursement denied.

- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 891 – No additional payment after reconsideration.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 197 – "Precertification/authorization/notification absent." 28 Texas Administrative Code §134.600 (p) (9) states,

   > all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);

   Review of the submitted medical claim finds the billed charges were $677.43. Therefore, the service did require pre-authorization. The requestor stated, "Authorization was later obtained from M. Moser, Adjuster with Texas Mutual, but after the initial application of the brace." Insufficient evidence found to support this statement within documents submitted at the request for Medical Fee Dispute Resolution.

   Therefore, the insurance carrier's denial reason supported. Reimbursement not recommended.

2. Based on requirements of Rule 134.600 (p) (9) not being met, the Division is unable to recommend payment.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		December 5, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.